

UNITED STATES BANKRUPTCY COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In Re:

TONYA M. COX

Chapter 7
Case No. 25-43010-tjt
Hon. Thomas J. Tucker

Debtors.

_____/

MICHIGAN DEPARTMENT OF HEALTH
AND HUMAN SERVICES,

Plaintiff,

Adv. Pro. No. _____
Hon. Thomas J. Tucker

v.

TONYA M. COX

Defendant.

_____/

**COMPLAINT TO DETERMINE DISCHARGEABILITY
OF DEBT UNDER 11 U.S.C. § 523(a)**

Plaintiff, Michigan Department of Health and Human Services
(Department), by and through its attorney, Assistant Attorney General
Adam M. Roose, objects to the discharge of the debt owed by Defendant
Tonya M. Cox pursuant to 11 U.S.C. § 523(a) and Fed. R. Bankr. P.
7001(6), and in support state as follows:

JURISDICTION

1. Pursuant to 28 U.S.C. § 157 and 28 U.S.C. § 1334, this Court has jurisdiction to determine the rights of the parties as to a determination of dischargeability of a debt under 11 U.S.C. § 523(a).

2. Venue is proper as provided by 28 U.S.C. § 1409(a).

3. This is a core proceeding pursuant to 28 U.S.C. § 157(b)(2)(I).

4. This is an action seeking a determination that the debt Tonya M. Cox owes to the Department is non-dischargeable pursuant to 11 U.S.C. § 523(a)(2)(A) and § 523(a)(7). Fed. R. Bankr. P. 4007(b); Fed. R. Bankr. P. 7001(6).

GENERAL ALLEGATIONS

5. The Department incorporates ¶¶ 1–4 by reference as if fully restated.

6. Cox's bankruptcy address of record and last known address shows that she resides in Wayne County at 13501 Village Square Dr., Apt. 303, Southgate, MI 48195

7. Cox filed a petition under Chapter 7 of the Bankruptcy Code on March 25, 2025. (Case No. 25-43010-tjt, ECF No. 1.)

The Department's Statutory and Regulatory Authority

8. The Department is an agency of the State of Michigan and, among other duties, is the lead agency for the administration of the federal Supplemental Nutrition Assistance Program (SNAP) pursuant to 7 U.S.C. § 2011, *et seq.*, and Mich. Comp. Laws § 400.10, *et seq.* The SNAP program is known in Michigan as the Food Assistance Program (FAP) (formerly known as the Food Stamp Program). Mich. Comp. Laws § 400.10.

9. The Department provides FAP benefits to eligible families based on total household income, family size, residency, and other qualifications. To receive FAP benefits, the applicant's disclosures must include all household members, all employment sources, and the total household income and assets must fall within the limits set by the Department. Mich. Comp. Laws § 400.10d. *See also* 7 C.F.R. § 273.9 (FAP eligibility); *Bridges Eligibility Manual* 212 (FAP group composition) and *Bridges Eligibility Manual* 550 (income) (available at <https://dhhs.michigan.gov/olmweb/ex/html/>). 7 C.F.R. § 273.12 (b)(1)(iii) (FAP eligibility). *See also* 7 C.F.R. § 273.9 (FAP eligibility); *Bridges Eligibility Manual* 212 (FAP group composition) and *Bridges Eligibility*

Manual 550 (income) (available at <https://dhhs.michigan.gov/olmweb/ex/html/>).

10. The Department is charged under state law with the recovery of overpaid FAP benefits. Mich. Comp. Laws § 400.43a, § 400.43b, § 400.60.

Cox's Pre-Petition Debt

11. Pre-petition Cox received State of Michigan FAP benefits during the period of December 1, 2005, through August 31, 2007 (the "Over-Issuance Period").

12. On July 25, 2005, Cox applied to the Department to receive FAP benefits. (Ex. 1, DHS 1171, 07/25/2005.)

13. As part of Cox's July 25, 2005, application, she represented to the Department her sole source of household income was from her employment at Marshall Fields. (Ex. 1, p. 4.)

14. By applying for and receiving FAP benefits, Cox was obligated to report all changes in household circumstances that might affect eligibility for benefits to the Department within ten days, e.g., new employment or receipt of additional earned household income, to the Department within ten days. Mich. Comp. Laws § 400.60(2)

(ongoing duty to report changes in circumstances may lead to decreased benefits eligibility); 7 C.F.R. § 273.12 (a)(1); and *Bridges Administrative Manual* 105, pp. 11–12 (<https://dhhs.michigan.gov/olmweb/ex/html/>).

15. Cox therefore knew or should have known that she was required to report changes in income or employment for all members in her household that would affect the level of benefits she received.

16. Cox however intentionally and knowingly misrepresented her eligibility to continue receiving FAP benefits during the Over-Issuance Period because she failed to report that her daughter, who was a member of Cox's household, became employed in October 2005 and started earning income from Wet Seal Retail, Inc. and from ZLB Bioplasma.

17. On June 7, 2006, Cox submitted a renewal application to the Department to continue receipt of FAP benefits. (Ex. 2, DHS 1171, 06/07/2006.)

18. As part of the June 7, 2006, application, Cox certified under penalty of perjury, that all information provided in her application was true and accurate. (Ex. 2, p. 7.)

19. In her June 7, 2006, application, Cox certified to the Department that neither she nor any member of her household was receiving income from employment. (Ex. 2, p. 4.)

20. Cox however failed to report in the June 7, 2006, application that both she and her daughter were employed at the time that the application was submitted.

21. Cox intentionally and knowingly misrepresented her eligibility to continue receiving FAP benefits because she failed to report household employment and receipt of earned income of both her and her daughter when submitting her June 7, 2006, renewal application to the Department.

22. Cox also intentionally and knowingly misrepresented her eligibility to continue receiving FAP benefits because she failed to report household employment and receipt of income for both her and her daughter within ten days and with each monthly benefit received from the Department. Mich. Comp. Laws § 400.60(2) (ongoing duty to report changes in circumstances may lead to decreased benefits eligibility); 7 C.F.R. § 274.2 (benefits are paid monthly).

23. The Department continued to provide Cox with FAP benefits during the Over-Issuance Period based on her failure to accurately and truthfully report her household income.

24. But for Cox's failure to properly disclose her household income during Over-Issuance Period, the Department would not have overpaid FAP benefits.

25. On November 12, 2009, Cox signed an Intentional Program Violation Repayment Agreement acknowledging that she failed to disclose household income during the Over-Issuance Period and agreeing to repay the overpayment to the Department. (Ex. 3, Repayment Agreement.)

26. In November 2009, Cox was charged with a felony count of welfare fraud in violation of Mich. Comp. Laws § 400.60 for failing to accurately and truthfully disclose her household income during the Over-Issuance Period. (Ex. 4, Wayne County Cir. Ct. Register of Actions.)

27. Cox entered a guilty plea to one count of welfare fraud more than \$500.00 and was sentenced on February 11, 2010, to three years of probation and ordered to pay restitution to the Department. (Ex. 5,

People of Michigan. v. Cox, 3rd Circuit Court, Order of Probation, issued 02/11/2010, [Docket No. 2009-029622-01-FH].)

28. As a result of Cox's intentional misrepresentation, the Department overpaid her \$7,229.00 (current balance is \$1,996.50) in FAP benefits that she was ineligible to receive. (Ex. 6, Claim Detail.)

COUNT I: – 11 U.S.C. § 523(a)(2)(A)

29. The Department incorporates by reference ¶¶ 1–28 as if fully restated.

30. The Department may obtain a determination of dischargeability regarding a kind of debt specified in § 523(a)(2)(A). Fed. R. Bankr. P. 4007(b).

31. During the Over-Issuance Period, Cox knowingly obtained and used FAP benefits that she was ineligible to receive.

32. When applying for FAP benefits, Cox was required to completely and accurately report all information that could affect her eligibility for benefits, including truthfully reporting to the Department all current household income and reporting any change in employment or earned household income.

33. Nonetheless, Cox intentionally and knowingly failed to report her daughter's earned income to the Department during the Over-Issuance Period.

34. Cox intentionally and knowingly engaged in a pattern and practice of failing to timely and accurately report her and her daughter's earned income in order to receive FAP benefits in excess of what she was actually eligible to receive during the Over-Issuance Period.

35. Cox intended that her misrepresentations would create the false impression that she was eligible to receive FAP benefits.

36. With each monthly payment for FAP benefits, Cox remained silent when under a statutory obligation to report changes in her household employment. Mich. Comp. Laws § 400.60.

37. Cox intended that her misrepresentations would create the false impression that she and all members of her household remained unemployed during the Over-Issuance Period.

38. The Department justifiably relied on Cox's intentional and false misrepresentations because she had a duty to submit truthful and accurate applications for FAP benefits to the Department.

39. Based on that reliance, the Department provided FAP benefits to Cox based on her ongoing misrepresentation that she and her household were unemployed and had no earned income during the Over-Issuance Period.

40. But for Cox's intentional misrepresentation and silence regarding her and her daughter's employment status during the Over-Issuance Period, she would not have continued to receive the same level of, or any, FAP benefits because eligibility for FAP benefits is tested against income.

41. Cox's receipt of FAP benefits during the Over-Issuance Period was through false pretenses, misrepresentations, silence, or actual fraud which is contrary to § 523(a)(2)(A).

42. The Department determined that Cox's false pretenses, misrepresentations, silence or actual fraud caused the overpayment of \$7,229 in FAP benefits during the Over-Issuance Period.

43. The current balance owed to the Department for overpaid FAP benefits is \$1,996.50.

COUNT II: 11 U.S.C. § 523(a)(2)(B)

44. The Department incorporates by reference ¶¶ 1–43 as if fully restated.

45. The Department may obtain a determination of dischargeability regarding a kind of debt specified in § 523(a)(2)(B). Fed. R. Bankr. P. 4007(c).

46. The June 7, 2006, application that Cox signed and submitted to the Department include statements in writing. (Ex. 2.)

47. The June 7, 2006, application became materially false because Cox misrepresented her household income by failing to report to the Department her earned income from employment and failing to report her daughter's earned income from employment.

48. But for Cox's ongoing misrepresentations regarding her household income, the Department would not have continued issuing her the same level of FAP benefits.

49. The June 7, 2006, application concerned Cox's financial condition because it pertained to household income, which is a critical factor in the determination of eligibility for, and ongoing receipt of FAP benefits.

50. Cox's misrepresentations were ongoing regarding her household income and impacted the Department's decision as to the amount of ongoing benefits Cox was eligible to receive because FAP benefits are based on the total household composition and total household income.

51. The Department did in fact reasonably rely on Cox's assertions about her household income in the June 7, 2006, application she submitted to the Department when it certified her FAP benefits for 12 months. *See* Bridges Administrative Manual 115, pp. 30–31 (applications certify benefits for up to 12 months); 7 C.F.R. § 273.10(f).

52. Cox completed and published the application with the intent that the Department would rely on her household employment assertions because she knew she had the duty to accurately disclose all household employment income and report all changes to the Department. Mich. Comp. Laws § 400.60(2).

53. And by continuing to receive and accept public benefits under the false premise that her household had no earned income from employment, Cox intended to make a materially false statement regarding her total household income and her financial eligibility for

public benefits. *See Missouri Div. of Family Servs. v. Jones (In re Jones)*, 37 B.R. 195 (Bankr. E.D. Mo. 1984) (§ 523[a][2][B] includes written statements that become materially false due to, for example, the failure to update employment status when required to do so by statute). *See also Hardwick Bank & Trust Co. v. Brown (In re Brown)*, 32 B.R. 554, 558 (Bankr. E.D. Tenn. 1983) (intentional fraud, or reckless indifference, for failure to disclose substantial change in financial condition between date of financial statements and creditor's loan commitment letter).

54. Cox's intentional and materially false statements regarding her household's financial condition, which were also incorporated into her written application, allowed her to obtain money or benefits from the Department contrary to § 523(a)(2)(B).

55. Cox's materially false statements caused the Department to overpay her \$7,229.00 (current balance is \$1,996.50) in FAP benefits during the Over-Issuance Period.

COUNT II – 11 U.S.C. § 523(a)(7)

56. The Department incorporates by reference ¶¶ 1–55 as if fully restated.

57. A debt is non-dischargeable if it is a “fine, penalty, or forfeiture payable to and for the benefit of a governmental unit[.]” 11 U.S.C. § 523(a)(7).

58. The Department is a “governmental unit.” 11 U.S.C. § 101(27).

59. On November 12, 2009, Cox pleaded guilty in 3rd Circuit Court for Wayne County (Case number 2009-029622-01-FH) to the crime of welfare fraud more than \$500.00, Mich. Comp. Laws § 400.60(1)(b). (Ex. 5, Order of Probation.)

60. Cox was ordered pay \$7,229.00 restitution for the conviction of welfare fraud. (*Id.*)

61. Restitution ordered to be paid to a governmental agency in a prepetition judgment is non-dischargeable under 11 U.S.C. § 523(a)(7). *In re Smith*, 547 B.R. 774, 778–779 (E.D. Mich. Mar. 1, 2016) (restitution from a state of Michigan criminal proceeding is non-

dischargeable); *In re Browning*, 449 B.R. 902, 905 (Bankr. W.D. Ky. 2011).

62. Cox's debt for the overpaid FAP benefits is non-dischargeable under § 523(a)(7) because the debt is for criminal restitution resulting from her conviction for welfare fraud and is payable to the Department, which is a governmental agency.

CONCLUSION AND REQUEST FOR RELIEF

WHEREFORE, the Michigan Department of Health and Human Services requests that this Court enter an Order as follows:

- A. Enter an order determining that the debts owed by Defendant Tonya M. Cox for \$7,229.00 in FAP benefits is non-dischargeable pursuant to 11 U.S.C. § 523(a)(2)(A), and § 523(a)(7);
- B. Enter a money judgment against Defendant Tonya M. Cox in favor of the Michigan Department of Health and Human Services in the total amount of \$1,996.50 (current combined balance owing), plus post-judgment interest and court filing costs in accordance with law; and

C. Grant any further relief as this Court deems appropriate.

Respectfully submitted,

/s/ Adam M. Roose

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Dated: June 18, 2025

Exhibit 1

<p>Do you need the department to provide an interpreter to help you at the interview? () yes () no If yes, what language? _____</p> <p>¿Necesita que le proporcione un intérprete para que le ayude en la entrevista? () si () no Si dice que sí, ¿que idioma hablan en su casa? _____</p> <p>هل تريد من الدائرة أن توفر لك مترجما كي يساعدك أثناء المقابلة؟ نعم () لا () إذا أجبت بنعم فما هي اللغة التي تتحدثها في المنزل؟ _____</p>		FOR OFFICE USE ONLY														
<p>Grantee Name: <u>COX TONYA</u></p> <p>Grantee Client ID: <u>52083305</u></p> <p>Case Number: _____</p>		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">County</td> <td style="width:15%;">District</td> <td style="width:15%;">Section</td> <td style="width:15%;">Unit</td> <td style="width:15%;">Specialist</td> </tr> <tr> <td><u>82</u></td> <td><u>35</u></td> <td><u>03</u></td> <td><u>07</u></td> <td><u>07</u></td> </tr> </table>					County	District	Section	Unit	Specialist	<u>82</u>	<u>35</u>	<u>03</u>	<u>07</u>	<u>07</u>
County	District	Section	Unit	Specialist												
<u>82</u>	<u>35</u>	<u>03</u>	<u>07</u>	<u>07</u>												
APPLICANT INFORMATION. PLEASE PRINT																
1. Name (First, Middle, Last) <u>TONYA Marie COX</u>		2. Date of Birth (Mo/Day/Yr) [REDACTED]		3. Phone Number [REDACTED]												
4. Residence Address (Number, Street, Rural Route, Apt. No.) <u>68 Schumacher Apt 687</u>		City <u>Southfield</u>		County	State <u>MI</u>	Zip code										
5. Mailing Address (If Different From Above)		City		County	State	Zip code										
6. Directions to Home <u>Southfield FWY to Grandriver then Grandriver to Schoolcraft</u>																
7. If anyone in your home uses a teletype for the deaf, enter TDD or TTY Number: ()		8. Name of person and phone number where you can be reached. Name (First, Last) <u>Dorothy Cox</u>		Phone No. [REDACTED]												
9. Is your household homeless? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
10. Do you and/or your household intend to stay in Michigan? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																
11. Have you and/or your household come to Michigan looking for work or with a job commitment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
12. Have you moved here or received money or benefits (Cash Assistance, Food Stamps, Medical Assistance, etc.) from another state since August of 1996? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
13. If yes, what state? _____ County: _____ When did you move? _____ Worker phone number: () _____																
14. Check the Programs you are applying for		<input checked="" type="checkbox"/> Cash Assistance (rent and other daily living expenses) <input type="checkbox"/> State Emergency Relief (utility shut-off, eviction notice, or other emergency) <input checked="" type="checkbox"/> Medical Assistance (doctor bills, hospital bills, prescriptions, Medicare premiums) <input type="checkbox"/> Child Development and Care (CDC, child care payments) <input checked="" type="checkbox"/> Food Assistance Benefits (FAP, food)														
15. If you live in a nursing home or institution, name of nursing home or institution:		Phone Number ()		Expected date of release:												
Address (number, street, rural route, apt. no.)		City		State	Zip code											
16. If you have a court-appointed guardian or conservator, name of guardian or conservator:		Do you pay guardian/conservator expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone number ()												
Address (number, street, rural route, apt. no.)		City		State	Zip code											
17. Have you ever applied for, or received, assistance from the State of Michigan? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		18 - 27 for FAP Only		18. If you are eligible for Food Assistance and want someone else to shop for you, enter the name of an authorized representative: <u>Latoya Cox</u>												
19. If you have received Food Assistance benefits before, do you still have your Bridge Card(s)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
20. What is the total amount of CASH assets belonging to your household? (Include cash, savings, checking, savings bonds, etc.) \$ <u>0</u>		21. What is the total INCOME your household will receive this month? (Include earnings, UCB, child support, Social Security benefits, etc.) \$ <u>1317.63</u>														
22. What is the total amount of your monthly rent and/or mortgage payment? \$ <u>795.00</u>		23. Do you pay for heat? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If you do not pay for heat check utilities you pay for <input checked="" type="checkbox"/> non heat electric <input type="checkbox"/> water/sewer <input checked="" type="checkbox"/> telephone <input type="checkbox"/> cooking fuel <input type="checkbox"/> garbage/trash														
24. Is anyone in your household a migrant or seasonal farmworker? If YES, please answer questions 25 through 27. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If NO, skip to 28.		25. Has anyone in your household received any income this month? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, how much? \$ <u>1317.63</u> When? <u>7-8-85 - 7-22-05</u>														
26. Did your household recently lose its only source of income? If YES, when? _____ <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Does anyone in your household expect to receive income this month? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, how much? \$ _____ When? _____ Any travel advance? <input type="checkbox"/> Yes <input type="checkbox"/> No														
28. If you are applying for someone else, complete the following information:																
Name (First, Middle, Last)		Relationship		Phone Number ()												
Address (Number, Street, Rural Route, Apt. No.)		City		State	Zip code											

1. ANSWER ALL QUESTIONS LISTED BELOW

- List yourself first and then all other persons who live in the home or are temporarily absent from your home.
- If you are applying for a patient in a nursing home, list the patient first, then the patient's spouse and other dependents at home, if any.

Enter this person's racial heritage from the codes below. If you are multiracial, you may enter all codes that apply.
(Answering this is voluntary.)

W = White
B = Black
S = Asian

I = American Indian
A = Alaskan Native
P = Native Hawaiian or Pacific Islander

Check box below if you are Hispanic or Latino.
(Answering this is voluntary.)

Line No.	NAME (First, Middle, Last)	Do you want benefits for this person?		Relationship to you	Date of birth Mo / Day / Year	Social security number for those applying for assistance	US Citizen Y or N	Sex M or F		
		Yes	No							
1	TONYA Marie COX	X		SELF			Y	F		<input type="checkbox"/>
2		X		daughter			Y	F		<input type="checkbox"/>
3		X		SON			Y	M		<input type="checkbox"/>
4										<input type="checkbox"/>
5										<input type="checkbox"/>
6										<input type="checkbox"/>
7										<input type="checkbox"/>
8										<input type="checkbox"/>

2. Is any person listed above under the age of 18 and the parent of a child listed? ☐ Yes ☒ No If yes, enter the following:
Person's name: Child's name:

3. Is any child listed above under the age of 3 months? ☐ Yes ☒ No If yes, enter the following:
Child's name: Mother's name:

4. Is any person:	Yes	No	If yes, Who?	Who?	Who?	Who?
Attending school	X					
Disabled, blind or unable to work						
Caring for a disabled child or spouse						
A refugee						
A migrant						
Pregnant				Due Date:		Due Date:
Expecting more than one child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many?

5. Is anyone in the home other than a parent acting as the parent to a person under 21 years of age? ☐ Yes ☒ No If yes, enter name of person: and child's name:

6. Complete the information for each applicant who is NOT a U.S. Citizen. Send copy of the document that provides the person's legal status.	Name and date of US entry	Name and date of US entry	Name and date of US entry	Name and date of US entry

7. Is anyone in your household an alien who was sponsored for admission into the U.S.? ☐ Yes, who? ☒ No

EMPLOYMENT AND TRAINING

	Yes	No	If Yes, who?
8. Is any person participating in a strike?		X	
9. Will any person begin a job before the end of the next calendar month?		X	
10. In the last 60 days has anyone: refused work, reduced the number of hours worked, quit a job, been laid off, or been fired?		X	

ADDITIONAL INFORMATION

	Yes	No	If Yes, who?
11. Is any person a U.S. armed forces veteran or widow, spouse, child or mother of a U.S. veteran?		X	
12. Is any person a fugitive felon? (answering this is voluntary if you are applying only for Medical Assistance.)		X	
13. Has any person ever been convicted of a felony for the possession, use or distribution of a controlled substance (drugs) occurring after August 22, 1996? (answering this is voluntary if you are applying only for Medical Assistance.)		X	
14. Does anyone applying have a husband or wife who is living someplace else?		X	
15. Are all children under 6 years of age up to date on their immunizations (shots)?			If No, who is not?
16. Do you or anyone in your home receive tribal food commodities?		X	If Yes, who?

Enter this person's marital status using the codes below: M — Married N — Never Married D — Divorced S — Separated W — Widowed		Does each person in the home buy, fix or eat food with person #1?	What was the highest school grade this person completed? (Use 13, 14, etc. for years past high school.)	Answer these questions for each person under 21 years old.																	
Line No.	Marital Status	Enter the date of marriage. Mo/Day/Yr	Yes	No	What was the highest school grade this person completed? (Use 13, 14, etc. for years past high school.)	A Enter the name of this person's father.		B Is this person's father in the home?		C If B is NO, is this person's father dead?		D If B and C are NO, were the parents married to each other?		E If B, C & D are NO, was paternity legally established?		F Enter the name of this person's mother.		G Is this person's mother in the home?		H If G is NO, is this person's mother dead?	
						Name	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Name	Yes	No	Yes	No
1	N				SELF																
2	N		X		10			X	X							TORNA-COX	X				
3	N		X		5			X	X			X	X			TORNA-COX	X				
4																					
5																					
6																					
7																					
8																					

17. If you need, or currently pay for, child care services, check why and explain. ☐ Work ☐ High school completion ☐ Health/social reasons
☐ Michigan Works! Agency (MWA) or other approved education or training
If applying for Food Assistance only, do not complete D or G. (includes approved post-secondary education)

A. Name of child needing care	B. Age	C. Cost of care and how often paid	D. Is provider related to child? How?	E. Name and address of care provider	F. Provider phone number	G. Provider ID Number

18. Is care provided in the home where the child lives?

☐ Yes ☐ No

19. Are you a foster parent to a child needing care?

☐ Yes ☐ No ☐ If yes, Who?

EMPLOYMENT INCOME

20. Is any person employed or self-employed, including odd jobs.

☒ Yes ☐ No ☐ If yes, and self employed, complete Section 21. All other yes responses, complete earned income on page 4. Include employment of all household members.

SELF-EMPLOYMENT

21. Name of self-employed person	22. Gross monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)	23. Is health insurance offered by business?	If Yes, enter amount of monthly premium, even if you are not covered by the insurance.	24. Type of business
	\$ per/month	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	\$ per/month	<input type="checkbox"/> Yes <input type="checkbox"/> No		

EARNED INCOME: (Answer All Questions)

Name of person with earnings <u>LOLLA COX</u>		Start date <u>6-2-05</u>	Will employment continue <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Is health insurance offered by your employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>After 6 months</u>		Enter the amount of monthly premiums even if you are not covered by the insurance <u>\$ med 22.78 den 3.94</u>		
Employer Name <u>Marshall Field's</u>		Monthly pay before taxes. <u>\$ 1228.02</u> (tips included)	Monthly take home pay after taxes. <u>\$ 1082.44</u> (tips included)	
Average number of hours per week <u>34.00</u>	How often paid (length of pay period) <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every other week <input type="checkbox"/> Other	Day of week paid <u>Friday</u>	Last pay date <u>7-22-05</u>	Amount of last check <u>245.94</u>
Rate of Pay <u>\$ 8.25</u> Hourly <u>\$</u> Salary <u>\$</u> Other		Tips/bonus received? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Tips included in gross income on check stub? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Average amount for tips \$ / hour \$ / week

Name of person with earnings		Start date	Will employment continue <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is health insurance offered by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		Enter the amount of monthly premiums even if you are not covered by the insurance \$		
Employer Name		Monthly pay before taxes. \$ (tips included)	Monthly take home pay after taxes. \$ (tips included)	
Average number of hours per week	How often paid (length of pay period) <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every other week <input type="checkbox"/> Other	Day of week paid	Last pay date	Amount of last check
Rate of pay \$ Hourly \$ Salary \$ Other		Tips/bonus received? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tips included in gross income on check stub? <input type="checkbox"/> Yes <input type="checkbox"/> No	Average amount for tips \$ / hour \$ / week

Name of person with earnings		Start date	Will employment continue <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is health insurance offered by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		Enter the amount of monthly premiums even if you are not covered by the insurance \$		
Employer Name		Monthly pay before taxes. \$ (tips included)	Monthly take home pay after taxes. \$ (tips included)	
Average number of hours per week	How often paid (length of pay period) <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every other week <input type="checkbox"/> Other	Day of week paid	Last pay date	Amount of last check
Rate of Pay \$ Hourly \$ Salary \$ Other		Tips/bonus received? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tips included in gross income on check stub? <input type="checkbox"/> Yes <input type="checkbox"/> No	Average amount for tips \$ / hour \$ / week

OTHER INCOME:

Does anyone receive money from:	Yes	No	If Yes, who receives?	Monthly amount	Claim #	If Yes, who receives?	Monthly amount	Claim #
Social Security Benefits (RSD)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<u>250.00</u>				
Supplemental Security Income (SSI)	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Veterans benefits	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
How Often Paid W = Weekly M = Monthly T = Twice a Month E = Every Other Week O = Other					How often paid?			How often paid?
Workers Compensation	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Disability benefits	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Child support	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Unemployment compensation	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Retirement benefits	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Military allotments	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Gaming distributions (Casino profit sharing)	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Is there any other income? Please specify	<input type="checkbox"/>	<input checked="" type="checkbox"/>						

 If you are applying for Food Assistance or Child Development and Care only do not complete this page.

ASSETS: Complete this section by providing requested asset information, including assets held jointly.

Does any person have any of the following:	Yes	No	Name(s) on the account	Name and address of bank, credit union, savings and loan	Account number	Balance
• Checking/Draft Accounts		<input checked="" type="checkbox"/>				
• Money Market Accounts		<input checked="" type="checkbox"/>				
• Savings/Share Accounts		<input checked="" type="checkbox"/>				
• Certificates of Deposit (C.D.)		<input checked="" type="checkbox"/>				
• Christmas Club Accounts		<input checked="" type="checkbox"/>				
• Patient Trust Fund		<input checked="" type="checkbox"/>				

Does any person have any of the following:	Yes	No	If Yes, give amount/value	Owner(s)	If Yes, give amount/value	Owner(s)
• Cash on hand or in safe deposit box		<input checked="" type="checkbox"/>				
• Real Estate (not including place you live) including income-producing and non-income-producing property		<input checked="" type="checkbox"/>				
• Mortgage, Land Contract or other notes payable to household member		<input checked="" type="checkbox"/>				
• Savings Bonds, Stocks or Mutual Funds		<input checked="" type="checkbox"/>				
• IRA, KEOGH, 401K or Deferred Compensation Account(s)		<input checked="" type="checkbox"/>				
• Trust funds		<input checked="" type="checkbox"/>				
• Life estate		<input checked="" type="checkbox"/>				
• Tools and equipment, livestock or crops		<input checked="" type="checkbox"/>				
• Life insurance or annuity		<input checked="" type="checkbox"/>				
• Burial plot(s), Casket, etc.		<input checked="" type="checkbox"/>				
• Burial Trust Funds/funeral contract(s)		<input checked="" type="checkbox"/>				
• Are there any other assets? Please specify		<input checked="" type="checkbox"/>				

ADDITIONAL ASSET INFORMATION

<p>Has any person sold or given away property, land, vehicles, stocks, bonds, savings, cash, checking, income, etc., closed any accounts or removed or added a name on any asset within the last 36 months?</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, Who? <u>TONYA COX</u></p>	<p>Have you, or has anyone who lives with you, received a one-time cash payment (such as worker's compensation, lottery winnings, insurance settlement, lawsuit award, etc.) within the last 36 months?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, Who? _____</p>
<p>Do you, or does any person living with you, have a pending lawsuit which may bring him/her money, property, etc.?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, Who? _____</p>	<p>Have you, or has anyone living with you, or has anyone acting for any household member, ever put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, Who? _____</p>

VEHICLE INFORMATION — List all vehicles owned or titled in the name of any person living in the home. Include vehicles owned jointly.

Name of vehicle owner(s) (As shown on vehicle title or registration)	Type of vehicle	Year	Make/ Model	Amount owed

If you are applying for Child Development and Care only, do not complete this page. Go to page 7.

SHELTER (HOUSING) EXPENSES			Yes	No	Amount Paid Per Month	MEDICAL INFORMATION			Yes	No	Amount You Pay Per Month
1. Does any person have a rent, mortgage or other shelter expense?	X				795.00	13. Does any person have any of the following medical expenses:					
2. Does any person have a second mortgage or home equity loan as part of their shelter expense?		X				• Medical/Dental care		X			
3. Do you live in HUD, Section 8, MSHDA subsidized housing?		X				• Prescription drugs		X			
4. Do you have any of the following expenses separate from rent or mortgage?						• Prescribed over-the-counter drugs		X			
• Homeowner's insurance		X			Per Yr	• Hospitalization or nursing home care		X			
• Property Taxes		X			Per Yr	• Dentures/hearing aids/eyeglasses		X			
• Mortgage Guarantee Insurance		X				• Prosthetics		X			
• Cooperative/condominium/or association fee		X				• Seeing eye/hearing dog		X			
• Special Assessments		X				• Transportation for medical care		X			
• Renter's Insurance	X				263.00 Per Yr	• Personal care/chore services		X			
• Mobile Home Lot Rent		X				14. Is any person covered, or was any person covered in the last 3 months by:	Yes	No		If Yes, enter current monthly premium you pay	
5. Do you or does your household share shelter expenses?		X				• Medicare Claim#		X			
6. Does your heat or utility meter service more than one unit?		X				• An employer's group health plan		X			
						• A health or hospital insurance policy other than Medicaid		X			
						• I would like more information about the AMP employer sponsored insurance option		X			
HEAT AND UTILITY EXPENSES						Do Not complete items 15-22 if applying for FAP Only.					
7. Do you have any of the following expenses separate from rent or mortgage?						15. Does any person have unpaid medical expenses for services provided in the last 3 months?	Yes	No		If Yes, Who?	
• Heat (gas, electric, propane, wood, etc.)		X				16. Does any person pay for transportation to receive medical care for pregnancy or an ongoing medical problem?					
• Electricity (non-heat)	X					17. Does any person go to an alcohol or drug treatment program?					
• Water/Sewer		X				18. Has any person set up a plan or entered into a contract, such as a life care contract, that will pay for his/her medical care?					
• Telephone	X					19. Has any person had an accident or work-related illness or injury resulting in medical costs that may be paid by another person or an insurance company?	Yes	No		If Yes, Who?	
• Cooking Fuel		X				20. Has any person applied for benefits from the Social Security Administration?					
• Garbage/Trash Pick up		X				21. If yes to above question, answer questions (a-d).	Yes	No		If Yes, When?	
• Other (write in): FOOD	X					a. Has this person been denied SSI benefits because the Social Security Administration decided he/she is not disabled?					
8. Does any person receive or expect to receive, a home heating credit from the Michigan Department of Treasury?		X				b. If yes to question a, has the SSI denial been appealed?					
OTHER LIVING ARRANGEMENTS						c. If yes to question a, has this person's health condition changed?					
9. Do you pay anyone you live with for:						d. If yes to c, check appropriate change					
• Rent and meals		X				<input type="checkbox"/> Different impairment					
• Rent only		X				<input type="checkbox"/> Additional impairment					
• Meals only		X				<input type="checkbox"/> Impairment worsened					
10. Do you live in a commercial boarding house?		X				22. Has anyone ever attended or is anyone now attending a special education	Yes	No		If Yes, Who?	
11. Do you live in:											
• A drug or alcohol abuse treatment center		X									
• An adult foster care home		X									
• A home for the aged		X									
• A county infirmary		X									
• A shelter for battered women		X									
• An emergency shelter		X									
OTHER EXPENSES											
12. Does any person pay court-ordered child support or alimony?		X			Per Month						

If yes, who pays?

25-04105-tt

Doc 1

Filed 06/18/25

Entered 06/18/25 10:23:02 Page 23 of 46

ASSIGNMENT OF BENEFITS**Support Payments.**

I understand that, as a condition of eligibility for the Family Independence Program, I am assigning to the Department of Human Services any rights to support I may have from another person for myself or any person for whom I am applying or receiving assistance. This assignment includes rights to present and future support, as well as support owed to me from past periods. Such payments will be used to reimburse the department up to the amount of assistance granted.

Recovery of Medical Costs.

I understand that when the Michigan Department of Community Health (MDCH) pays the cost of hospital, surgical, or medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the MDCH. Payment of any recovery under such right is to be made directly to the State of Michigan — MDCH.

Supplemental Security Income (SSI) Payments.

I authorize the Social Security Administration to make my first Supplemental Security Income (SSI) payment to the Department of Human Services (DHS), if I file an SSI claim for up to one year after the date this application is received by DHS. I further permit the DHS to deduct from such first payment an amount that is enough to pay back my interim assistance. After keeping such amount, the DHS shall promptly pay the balance, if any, to me. I understand that I have the right to a hearing from the DHS if I disagree with the amount deducted from the first payment. Interim assistance means State Disability Assistance money paid to meet my basic needs, excluding assistance payments financed wholly or partly with federal funds, while my SSI claim is pending. If I receive the first SSI benefits payment directly, I agree to pay the DHS promptly for any interim assistance advanced while the claim for SSI was pending. This release is **not** to be regarded by the Social Security Administration (SSA) as an intent to file for SSI unless I actually file a claim for SSI, on a prescribed form, within 60 days.

RELEASES**Social Security Information.**

I authorize the Social Security Administration to give to the Department of Human Services all information necessary to determine my eligibility for benefits under the Family Independence Program, Medicaid, Food Assistance, Child Development and Care, State Disability Assistance, or State medical programs until the second month following the expiration of my eligibility based on the current application.

Child Support Payment Information

I authorize release of child support payment information from the Michigan Child Support Enforcement System for myself or for any person for whom I am applying for or receiving assistance for under the Family Independence Program, Medicaid, Food Assistance, Child Development and Care, State Disability or state medical programs.

Charitable Groups.

I authorize the department to give my name, the first name(s) and age(s) of the child(ren) living with me, and my address when requested by a charitable group whose purpose is to provide goods or services to my household. The group must be known to DHS staff for its charitable work. The information given to the group cannot be used for personal, political, commercial or religious reasons.

Child Development and Care.

I authorize the department to send notices and/or provide information to my child care provider(s) when: 1) child care services have been authorized, or 2) when there are changes in the authorization information previously given to the provider, or 3) my application for Child Development and Care (CDC) services is denied or withdrawn, or 4) my CDC case is cancelled. I also authorize the department or any child care center that may provide care for my child(ren) to release information necessary to determine my right to benefits under any local, state or federal program.

Eligibility Information.

I understand that the information I have provided will be used to make sure my household is eligible for Food Assistance benefits, other federal and state assistance programs, and federally assisted state programs such as school lunch, Family Independence Program, and Medicaid. Fraudulent participation in the Food Assistance Program may result in criminal or civil action or administrative claims. I understand that this application may be chosen for further Department investigation.

AFFIDAVIT

I certify, under penalty of perjury, that all the information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out any information or if I have given false information, which causes me to receive assistance I am **not** entitled to or more assistance than I am entitled to, I can be prosecuted for fraud and/or required to repay the amount wrongfully received.

IMPORTANT: YOU MUST SIGN THE APPLICATION

I certify that I have received and reviewed a copy of the Acknowledgments, that explains additional information about applying for and receiving assistance benefits.

Signatures: Customer or Representative

Date

Department Witness

(when in-person interview completed)

Lead #

Date

Signature of Migrant Recruiter

Date

Migrant Recruiter Address

FOR OFFICE USE ONLY

NOTES

7/20/05 MS. Cox is in the office today for credit
for med. MS. Cox is applying for P.A.P. MS. Cox
~~pay~~ is employed 34 hr per wk and make
8.25 per hr. MS. Cox is pay \$ 795.00 per
month for rent and pay for light and phone.

M. Morgan

Exhibit 2

Do you need the department to provide an interpreter to help you at the interview? () yes () no If yes, what language? _____

Necesita que le proporcione un intérprete para que le ayude en la entrevista? () si () no
 ¿dice que sí, ¿que idioma hablan en su casa? _____

هل تريد من الدائرة أن توفر لك مترجما كي يساعدك أثناء المقابلة؟
 نعم () لا () إذا أجبت بنعم فما هي اللغة التي تتحدثها في المنزل؟ _____

FOR OFFICE USE ONLY

Grantee Name

COX TONYA

Grantee Client ID

52083305

Case Number

County

82

District

35

Section

03

Unit

07

Specialist

01

APPLICANT INFORMATION. PLEASE PRINT

Name (First, Middle, Last)

Tonya Marie Cox

2. Date of Birth (Mo/Day/Yr)

3. Phone Number

Residence Address (Number, Street, Rural Route, Apt. No.)

1620 Memorial

City

Detroit

County

Wayne

State

MI

Zip code

48227

Mailing Address (If Different From Above)

City

County

State

Zip code

Directions to Home

Schoolcraft to Memorial make left

Does anyone in your home use a teletype for deaf, enter TDD or TTY Number:

()

8. Name of person and phone number where you can be reached.
Name (First, Last)

Dorothy Cox

Phone No.

Are you and/or your household homeless?

☐ Yes ☒ No

Do you and/or your household intend to stay in Michigan?

☒ Yes ☐ No

Have you and/or your household come to Michigan looking for work or with a job commitment?

☐ Yes ☒ No

Have you moved here or received money or benefits (Cash Assistance, Food Stamps, Medical Assistance, etc.)

from another state since August of 1996?

☐ Yes ☒ No

If yes, what state? _____

County: _____

When did you move? _____

Worker phone number: () _____

Check the programs you are applying for

☒ Cash Assistance (rent and other daily living expenses)☐ State Emergency Relief (utility shut-off, eviction☒ Medical Assistance (doctor bills, hospital bills, prescriptions, Medicare premiums) notice, or other emergency)☒ Food Assistance Benefits (FAP, food)☐ Child Development and Care (CDC, child care payments)

If you live in a nursing home or institution, name of nursing home or institution:

Phone Number

()

Expected date of release:

Address (number, street, rural route, apt. no.)

City

State

Zip code

If you have a court-appointed guardian or conservator, name of guardian or conservator:

Do you pay guardian/conservator expenses? ☐ Yes ☐ No

Phone number

()

Address (number, street, rural route, apt. no.)

City

State

Zip code

Have you ever applied for, or received, assistance from the State of Michigan?

☒ Yes ☐ No

18 - 27 for FAP Only

18. If you are eligible for Food Assistance and want someone else to shop for you, enter the name of an authorized representative:

If you have received Food Assistance benefits before, do you still have your Bridge Card(s)?

☒ Yes ☐ No

What is the total amount of CASH assets belonging to your household?

(Include cash, savings, checking, savings bonds, etc.) \$ 0

21. What is the total INCOME your household will receive this month? (Include earnings, UCB, child support, Social Security benefits, etc.) \$ 250.00

What is the total amount of your monthly rent and/or mortgage payment?

\$ 650.00

23. Do you pay for heat? ☒ Yes ☐ NoIf you do not pay for heat check utilities you pay for ☐ non heat electric☐ water/sewer ☐ telephone ☐ cooking fuel ☐ garbage/trash

24. Is anyone in your household a migrant or seasonal farmworker?

If YES, please answer questions 25 through 27.

☐ Yes ☒ No

If NO, skip to 28.

25. Has anyone in your household received any income this month? ☒ Yes ☐ No

If YES, how much? \$ 250.00 When? _____

26. Did your household recently lose its only source of income?

☐ Yes ☒ No

If YES, when? _____

27. Does anyone in your household expect to receive income this month? ☒ Yes ☐ No

If YES, how much? \$ 250.00

When? 6.3.06

Any travel advance? ☐ Yes ☒ No

28. If you are applying for someone else, complete the following information:

Name (First, Middle, Last)

Relationship

Phone Number

()

Address (Number, Street, Rural Route, Apt. No.)

City

State

Zip code

1. ANSWER ALL QUESTIONS LISTED BELOW

- List yourself first and then all other persons who live in the home or are temporarily absent from your home.
- If you are applying for a patient in a nursing home, list the patient first, then the patient's spouse and other dependents at home, if any.

Enter this person's racial heritage from the codes below. If you are multiracial, you may enter all codes that apply.
(Answering this is voluntary.)

W = White
B = Black
S = Asian

I = American Indian
A = Alaskan Native
P = Native Hawaiian or Pacific Islander

Check box below if you are Hispanic or Latino.
(Answering this is voluntary.)

Line No.	NAME (First, Middle, Last)	Do you want benefits for this person?		Relationship to you	Date of birth Mo / Day / Year	Social security number for those applying for assistance	US Citizen Y or N	Sex M or F		
		Yes	No							
1	Tonya M Cox	X		SELF			Y	F		<input type="checkbox"/>
2		X		daughter			Y	F		<input type="checkbox"/>
3		X		daughter			Y	F		<input type="checkbox"/>
4		X		son			Y	M		<input type="checkbox"/>
5										<input type="checkbox"/>
6										<input type="checkbox"/>
7										<input type="checkbox"/>
8										<input type="checkbox"/>

2. Is any person listed above under the age of 18 and the parent of a child listed? ☐ Yes ☐ No ☒ If yes, enter the following:
Person's name: _____ Child's name: _____

3. Is any child listed above under the age of 3 months? ☐ Yes ☐ No ☒ If yes, enter the following:
Child's name: _____ Mother's name: _____

4. Is any person :	Yes	No	If yes, Who?	Who?	Who?	Who?
Attending school	X					
Disabled, blind or unable to work		X				
Caring for a disabled child or spouse		X				
A refugee		X				
A migrant		X				
Pregnant				Due Date		Due Date
Expecting more than one child?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, how many?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many?

5. Is anyone in the home other than a parent acting as the parent to a person under 21 years of age? ☐ Yes ☒ No If yes, enter name of person: _____ and child's name: _____

6. Complete the information for each applicant who is NOT a U.S. Citizen. Send copy of the document that provides the person's legal status.	Name and date of US entry	Name and date of US entry	Name and date of US entry	Name and date of US entry

7. Is anyone in your household an alien who was sponsored for admission into the U.S.? ☐ Yes, who? _____ ☒ No

EMPLOYMENT AND TRAINING

	Yes	No	If Yes, who?
8. Is any person participating in a strike?		X	
9. Will any person begin a job before the end of the next calendar month?		X	
10. In the last 60 days has anyone: refused work, reduced the number of hours worked, quit a job, been laid off, or been fired?	X		Tonya Cox

ADDITIONAL INFORMATION

	Yes	No	If Yes, who?
11. Is any person a U.S. armed forces veteran or widow, spouse, child or mother of a U.S. veteran?		X	
12. Is any person a fugitive felon? (answering this is voluntary if you are applying only for Medical Assistance.)		X	
13. Has any person ever been convicted of a felony for the possession, use or distribution of a controlled substance (drugs) occurring after August 22, 1996? (answering this is voluntary if you are applying only for Medical Assistance.)		X	
14. Does anyone applying have a husband or wife who is living someplace else?		X	
15. Are all children under 6 years of age up to date on their immunizations (shots)?			If No, who is not?
16. Do you or anyone in your home receive tribal food commodities?		X	If Yes, who?

ANSWER ALL QUESTIONS LISTED BELOW

1. (Cont'd from top of page 2.)

Enter this person's marital status using the codes below: M — Married N — Never Married D — Divorced S — Separated W — Widowed		Does each person in the home buy, fix or eat food with person #1?	What was the highest school grade this person completed? (Use 13, 14, etc. for years past high school.)	Answer these questions for each person under 21 years old.													
Line No.	Enter the date of marriage, Mo/Day/Yr	Yes	No	A Enter the name of this person's father.	B Is this person's father in the home?		C If B is NO, is this person's father dead?		D If B and C are NO, were the parents married to each other?		E If B, C & D are NO, was paternity legally established?		F Enter the name of this person's mother.	G Is this person's mother in the home?		H If G is NO, is this person's mother dead?	
					Name	Yes	No	Yes	No	Yes	No	Yes		No	Name	Yes	No
1	N			SELF		X	X						Dorothy Cox		X		X
2	N	X				X	X						Tonya Cox	X			X
3	N	X				X	X						Tonya Cox	X			X
4	N	X				X		X					Tonya Cox	X			X
5																	
6																	
7																	
8																	

17. If you need, or currently pay for, child care services, check why and explain.

If applying for Food Assistance only, do not complete D or G. (includes approved post-secondary education)

A. Name of child needing care	B. Age	C. Cost of care and how often paid	D. Is provider related to child? How?	E. Name and address of care provider	F. Provider phone number	G. Provider ID Number

18. Is care provided in the home where the child lives?

☐ Yes ☐ No

19. Are you a foster parent to a child needing care?

☐ Yes ☐ No ▶ If yes, Who?
EMPLOYMENT INCOME

20. Is any person employed or self-employed, including odd jobs.

☐ Yes ☒ No ▶ If yes, and self employed, complete Section 21. All other yes responses, complete earned income on page 4. Include employment of all household members.
SELF-EMPLOYMENT

21. Name of self-employed person	22. Gross monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)	23. Is health insurance offered by business?	If Yes, enter amount of monthly premium, even if you are not covered by the insurance.	24. Type of business
	\$ per/month	<input type="checkbox"/> Yes <input type="checkbox"/> No	▶	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	▶	

EARNED INCOME: (Answer All Questions)

Name of person with earnings				Start date		Will employment continue <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is health insurance offered by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No				Enter the amount of monthly premiums \$ even if you are not covered by the insurance			
Employer Name		Monthly pay before taxes. \$ (tips included)		Monthly take home pay after taxes. \$ (tips included)			
Average number of hours per week	How often paid (length of pay period) <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every other week <input type="checkbox"/> Other		Day of week paid	Last pay date		Amount of last check	
Rate of Pay \$ Hourly \$ Salary \$ Other			Tips/bonus received? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tips included in gross income on check stub? <input type="checkbox"/> Yes <input type="checkbox"/> No		Average amount for tips \$ / hour \$ / week	

Name of person with earnings				Start date		Will employment continue <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is health insurance offered by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No				Enter the amount of monthly premiums \$ even if you are not covered by the insurance			
Employer Name		Monthly pay before taxes. \$ (tips included)		Monthly take home pay after taxes. \$ (tips included)			
Average number of hours per week	How often paid (length of pay period) <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every other week <input type="checkbox"/> Other		Day of week paid	Last pay date		Amount of last check	
Rate of pay \$ Hourly \$ Salary \$ Other			Tips/bonus received? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tips included in gross income on check stub? <input type="checkbox"/> Yes <input type="checkbox"/> No		Average amount for tips \$ / hour \$ / week	

Name of person with earnings				Start date		Will employment continue <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is health insurance offered by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No				Enter the amount of monthly premiums \$ even if you are not covered by the insurance			
Employer Name		Monthly pay before taxes. \$ (tips included)		Monthly take home pay after taxes. \$ (tips included)			
Average number of hours per week	How often paid (length of pay period) <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every other week <input type="checkbox"/> Other		Day of week paid	Last pay date		Amount of last check	
Rate of Pay \$ Hourly \$ Salary \$ Other			Tips/bonus received? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tips included in gross income on check stub? <input type="checkbox"/> Yes <input type="checkbox"/> No		Average amount for tips \$ / hour \$ / week	

OTHER INCOME:

Does anyone receive money from:	Yes	No	If Yes, who receives?	Monthly amount	Claim #	If Yes, who receives?	Monthly amount	Claim #
Social Security Benefits (RSDI)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		2500				
Supplemental Security Income (SSI)	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Veterans benefits	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
How Often Paid W = Weekly M = Monthly T = Twice a Month E = Every Other Week O = Other					How often paid?			How often paid?
Workers Compensation	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Disability benefits	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Child support	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Unemployment compensation	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Retirement benefits	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Military allotments	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Gaming distributions (Casino profit sharing)	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
Is there any other income? Please specify	<input type="checkbox"/>	<input checked="" type="checkbox"/>						

If you are applying for Food Assistance or Child Development and Care only do not complete this page.

ASSETS: Complete this section by providing requested asset information, including assets held jointly.

Does any person have any of the following:	Yes	No	Name(s) on the account	Name and address of bank, credit union, savings and loan	Account number	Balance
• Checking/Draft Accounts		<input checked="" type="checkbox"/>				
• Money Market Accounts		<input checked="" type="checkbox"/>				
• Savings/Share Accounts		<input checked="" type="checkbox"/>				
• Certificates of Deposit (C.D.)		<input checked="" type="checkbox"/>				
• Christmas Club Accounts		<input checked="" type="checkbox"/>				
• Patient Trust Fund		<input checked="" type="checkbox"/>				

Does any person have any of the following:	Yes	No	If Yes, give amount/value	Owner(s)	If Yes, give amount/value	Owner(s)
• Cash on hand or in safe deposit box		<input checked="" type="checkbox"/>				
• Real Estate (not including place you live) including income-producing and non-income-producing property		<input checked="" type="checkbox"/>				
• Mortgage, Land Contract or other notes payable to household member		<input checked="" type="checkbox"/>				
• Savings Bonds, Stocks or Mutual Funds		<input checked="" type="checkbox"/>				
• IRA, KEOGH, 401K or Deferred Compensation Account(s)		<input checked="" type="checkbox"/>				
• Trust funds		<input checked="" type="checkbox"/>				
• Life estate		<input checked="" type="checkbox"/>				
• Tools and equipment, livestock or crops		<input checked="" type="checkbox"/>				
• Life insurance or annuity		<input checked="" type="checkbox"/>				
• Burial plot(s), Casket, etc.		<input checked="" type="checkbox"/>				
• Burial Trust Funds/funeral contract(s)		<input checked="" type="checkbox"/>				
• Are there any other assets? Please specify		<input checked="" type="checkbox"/>				

ADDITIONAL ASSET INFORMATION

Has any person sold or given away property, land, vehicles, stocks, bonds, savings, cash, checking, income, etc., closed any accounts or removed or added a name on any asset within the last 36 months?

☐ Yes ☒ No If yes, Who? _____

Do you, or does any person living with you, have a pending lawsuit which may bring him/her money, property, etc.?

☐ Yes ☒ No If yes, Who? _____

Have you, or has anyone who lives with you, received a one-time cash payment (such as worker's compensation, lottery winnings, insurance settlement, lawsuit award, etc.) within the last 36 months?

☐ Yes ☐ No If yes, Who? _____

Have you, or has anyone living with you, or has anyone acting for any household member, ever put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device?

☐ Yes ☐ No If yes, Who? _____

VEHICLE INFORMATION — List all vehicles owned or titled in the name of any person living in the home. Include vehicles owned jointly.

Name of vehicle owner(s) (As shown on vehicle title or registration)	Type of vehicle	Year	Make/ Model	Amount owed

If you are applying for Child Development and Care only, do not complete this page. Go to page 1

SHELTER (HOUSING) EXPENSES			Yes	No	Amount Paid Per Month	MEDICAL INFORMATION			Yes	No	Amount You Pay Per Month
1.	Does any person have a rent, mortgage or other shelter expense?		X		650.00	13.	Does any person have any of the following medical expenses:				
2.	Does any person have a second mortgage or home equity loan as part of their shelter expense?			X			• Medical/Dental care		X		
3.	Do you live in HUD, Section 8, MSHDA subsidized housing?			X			• Prescription drugs		X		
4.	Do you have any of the following expenses separate from rent or mortgage?						• Prescribed over-the-counter drugs		X		
	• Homeowner's insurance			X	Per Yr		• Hospitalization or nursing home care		X		
	• Property Taxes			X	Per Yr		• Dentures/hearing aids/eyeglasses		X		
	• Mortgage Guarantee Insurance			X			• Prosthetics		X		
	• Cooperative/condominium/or association fee			X			• Seeing eye/hearing dog		X		
	• Special Assessments			X			• Transportation for medical care		X		
	• Renter's Insurance			X	Per Yr		• Personal care/chore services		X		
	• Mobile Home Lot Rent			X		14.	Is any person covered, or was any person covered in the last 3 months by:	Yes	No	If Yes, enter current monthly premium you pay.	
5.	Do you or does your household share shelter expenses?			X			• Medicare		X		
6.	Does your heat or utility meter service more than one unit?			X			Claim#		X		
HEAT AND UTILITY EXPENSES			Yes	No	Amount you pay Per Month		• An employer's group health plan		X		
7.	Do you have any of the following expenses separate from rent or mortgage?						• A health or hospital insurance policy other than Medicaid		X		
	• Heat (gas, electric, propane, wood, etc.)		X				• I would like more information about the AMP employer sponsored insurance option		X		
	• Electricity (non-heat)		X			Do Not complete Items 15-22 if applying for FAP Only.					
	• Water/Sewer			X		15.	Does any person have unpaid medical expenses for services provided in the last 3 months?	Yes	No	If Yes, Who?	
	• Telephone			X					X		
	• Cooking Fuel			X		16.	Does any person pay for transportation to receive medical care for pregnancy or an ongoing medical problem?		X		
	• Garbage/Trash Pick up			X		17.	Does any person go to an alcohol or drug treatment program?		X		
	• Other (write in):			X		18.	Has any person set up a plan or entered into a contract, such as a life care contract, that will pay for his/her medical care?		X		
8.	Does any person receive or expect to receive, a home heating credit from the Michigan Department of Treasury?			X		19.	Has any person had an accident or work-related illness or injury resulting in medical costs that may be paid by another person or an insurance company?	Yes	No	If Yes, Who?	
OTHER LIVING ARRANGEMENTS			Yes	No	Amount you pay Per Month				X		
9.	Do you pay anyone you live with for:			X		20.	Has any person applied for benefits from the Social Security Administration?		X		
	• Rent and meals			X		21.	If yes to above question, answer questions (a-d).	Yes	No	If Yes, When?	
	• Rent only			X			a. Has this person been denied SSI benefits because the Social Security Administration decided he/she is not disabled?		X		
	• Meals only			X			b. If yes to question a, has the SSI denial been appealed?		X		
10.	Do you live in a commercial boarding house?			X			c. If yes to question a, has this person's health condition changed?		X		
11.	Do you live in:			X			d. If yes to c, check appropriate change				
	• A drug or alcohol abuse treatment center			X			<input type="checkbox"/> Different impairment				
	• An adult foster care home			X			<input type="checkbox"/> Additional impairment				
	• A home for the aged			X			<input type="checkbox"/> Impairment worsened				
	• A county infirmary			X		22.	Has anyone ever attended or is anyone	Yes	No	If Yes, Who?	
	• A shelter for battered women			X			now attending a special education class?		X		
	• An emergency shelter			X							
OTHER EXPENSES			Yes	No	Amount You Pay						
12.	Does any person pay court-ordered child support or alimony?			X	Per Month						
	If yes, who pays?			X							

ASSIGNMENT OF BENEFITS**Support Payments.**

I understand that, as a condition of eligibility for the Family Independence Program, I am assigning to the Department of Human Services any rights to support I may have from another person for myself or any person for whom I am applying or receiving assistance. This assignment includes rights to present and future support, as well as support owed to me from past periods. Such payments will be used to reimburse the department up to the amount of assistance granted.

Recovery of Medical Costs.

I understand that when the Michigan Department of Community Health (MDCH) pays the cost of hospital, surgical, or medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the MDCH. Payment of any recovery under such right is to be made directly to the State of Michigan — MDCH.

Supplemental Security Income (SSI) Payments.

I authorize the Social Security Administration to make my first Supplemental Security Income (SSI) payment to the Department of Human Services (DHS), if I file an SSI claim for up to one year after the date this application is received by DHS. I further permit the DHS to deduct from such first payment an amount that is enough to pay back my interim assistance. After keeping such amount, the DHS shall promptly pay the balance, if any, to me. I understand that I have the right to a hearing from the DHS if I disagree with the amount deducted from the first payment. Interim assistance means State Disability Assistance money paid to meet my basic needs, excluding assistance payments financed wholly or partly with federal funds, while my SSI claim is pending. If I receive the first SSI benefits payment directly, I agree to pay the DHS promptly for any interim assistance advanced while the claim for SSI was pending. This release is **not** to be regarded by the Social Security Administration (SSA) as an intent to file for SSI unless I actually file a claim for SSI, on a prescribed form, within 60 days.

RELEASES**Social Security Information.**

I authorize the Social Security Administration to give to the Department of Human Services all information necessary to determine my eligibility for benefits under the Family Independence Program, Medicaid, Food Assistance, Child Development and Care, State Disability Assistance, or State medical programs until the second month following the expiration of my eligibility based on the current application.

Child Support Payment Information

I authorize release of child support payment information from the Michigan Child Support Enforcement System for myself or for any person for whom I am applying for or receiving assistance for under the Family Independence Program, Medicaid, Food Assistance, Child Development and Care, State Disability or state medical programs.

Charitable Groups.

I authorize the department to give my name, the first name(s) and age(s) of the child(ren) living with me, and my address when requested by a charitable group whose purpose is to provide goods or services to my household. The group must be known to DHS staff for its charitable work. The information given to the group cannot be used for personal, political, commercial or religious reasons.

Child Development and Care.

I authorize the department to send notices and/or provide information to my child care provider(s) when: 1) child care services have been authorized, or 2) when there are changes in the authorization information previously given to the provider, or 3) my application for Child Development and Care (CDC) services is denied or withdrawn, or 4) my CDC case is cancelled. I also authorize the department or any child care center that may provide care for my child(ren) to release information necessary to determine my right to benefits under any local, state or federal program.

Eligibility Information.

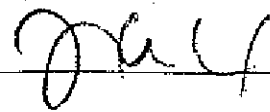
I understand that the information I have provided will be used to make sure my household is eligible for Food Assistance benefits, other federal and state assistance programs, and federally assisted state programs such as school lunch, Family Independence Program, and Medicaid. Fraudulent participation in the Food Assistance Program may result in criminal or civil action or administrative claims. I understand that this application may be chosen for further Department investigation.

AFFIDAVIT

I certify, under penalty of perjury, that all the information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out any information or if I have given false information, which causes me to receive assistance I am **not** entitled to or more assistance than I am entitled to, I can be prosecuted for fraud and/or required to repay the amount wrongfully received.

IMPORTANT: YOU MUST SIGN THE APPLICATION

I certify that I have received and reviewed a copy of the Acknowledgments, that explains additional information about applying for and receiving assistance benefits.

Signatures: Customer or Representative	Date	Department Witness (when in-person interview completed)	Lead #	Date
	6-7-06	M. Morgan	35030707	6-7-06
Signature of Migrant Recruiter	Date	Migrant Recruiter Address		

FOR OFFICE USE ONLY

NOTES

6-7-06
Mrs. Cox is in the Office today to apply for FFP
Mrs. Cox is not employed her last day of
work was 3-23-06 Mrs. Cox pay \$650.00 per
month for rent and for gas, light.

Exhibit 3

**INTENTIONAL PROGRAM VIOLATION
REPAYMENT AGREEMENT**
State of Michigan
Department of Human Services
OFFICE OF INSPECTOR GENERAL

Grantee Name		
TONYA COX		
Case Number		
919A		
County	District	OIG Agent
82	35	32
OIG INV#		Date
1000269800		6/26/2009

You received more benefits than you were eligible to receive from the Department of Human Services (DHS) during the period of 12/1/2005 to 8/31/2007.

The total overpayment is:

_____	for the Family Independence Program (FIP or ADC)
_____	for the State Disability Program (SDA)
<u>\$7,229.00</u>	for the Food Assistance Program (FAP or FS)
_____	for the _____ Program

The reason for this overpayment of benefits is:

☒ Your failure to provide complete information about: Unreported earnings from V [REDACTED]'s employment with Wet Seal Retail, and ZLB Bioplasma. Unreported earnings from Tonya's employment with K-Mart & JC Pennys.

☒ It has been determined that your FAP benefits were trafficked.

As evidenced by: DHS Application, Employment verification records, Benefit history

The attached Overissuance Summary explains how the amount of your overissuance was calculated.

You have the right to inspect and request copies of records related to this overissuance.

Page 2 of this form must be signed and returned by _____, otherwise further action will be taken by DHS.

OIG Agent	Phone #
J. Lofton/32	313 852-2057
Address	
3038 W. Grand Blvd., Ste 6-500, Detroit, MI 48202	

<p>If you do not understand this, call your local Department of Human Services. Si Ud. no entiende esto, llame a su oficina local del Department of Human Services إذا قابلت صعوبة في فهم هذا الطلب - الرجاء الإتصال بمكتبك المحلي لإدارة الخدمات الإنسانية</p>	<p>AUTHORITY: 7 USC 2022; 7 CFR 273.16; MCL 400.60; 4 400.3011; R 400.3129-R 400.3131; R 400.3159; R 400.3177-R 400.3179; R 400.5014 COMPLETION: Voluntary PENALTY: None</p>
<p>Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.</p>	<p>"In accordance with Federal Law and U.S. department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.</p>

Grantee Name Tonya Cox	Case Number 919A
----------------------------------	----------------------------

REPAYMENT TERMS (Program Administrative Manual Items 700, 720, 725, 730)

The law requires that you repay this overissuance (OI) to the Department of Human Services. These are the choices you have for repaying this overissuance:

1. **LUMP SUM CASH REPAYMENT:** You may choose to make an initial cash payment of all or part of the overissuance.
2. **ADMINISTRATIVE RECOUPMENT (BENEFIT REDUCTION):** If your case is active for the program in which the overissuance occurred, your benefits will be reduced until the full amount is repaid to DHS. If you are active for FIP or SDA, your grant will be reduced by 10% of your total needs (or a lesser amount to keep your cash grant at \$2). If you are active for FAP, your benefits will be reduced by 20% of your monthly benefit or \$20 per month (whichever is higher).
3. **CHILD DEVELOPMENT AND CARE (CDC) overissuances** must be paid in cash while the CDC case is active or closed. The minimum required cash payment for CDC is \$50 per month.
4. **FOOD ASSISTANCE SUPPLEMENTS:** If you become eligible for supplemental FAP benefits while you still owe an overissuance balance, the supplemental issuance will be used in part or in whole to repay the balance.
5. **EXPUNGED EBT BENEFITS:** If you do not use your EBT food assistance benefits for over one year, the balance will be expunged. These expunged FAP benefits will be applied to any outstanding OI.
6. **MONTHLY CASH PAYMENTS:** If your case is inactive for the program in which the overissuance occurred, you must pay monthly cash payments on the outstanding OI.

CASH RECOUPMENT: I agree to make monthly cash payments until the debt is paid in full. I will pay the balance of **\$7,229.00** in monthly cash payments of \$50 or 10% of my after-tax monthly family income (whichever is greater).

Payments will be split equally among the programs overissued. Payments are due on the 1st of each month beginning JAN. 2010 and continuing until paid in full.

OTHER RECOUPMENT INFORMATION: I understand that if my case closes or reopens, the manner of recoupment will change from administrative to cash or from cash to administrative as described above.

OFFSET: The State of Michigan may withhold any refund (including state income tax) or payment (including lottery winnings) to which I may be entitled from the State of Michigan as additional payment on this debt, regardless of whether I am repaying the debt via cash recoupment or administrative recoupment.

DEFAULT: Permission to make installment payments may be withdrawn, and the entire debt will be due immediately, if I default on the conditions of this agreement for more than 60 days or if it is determined that collection of this debt is endangered. If the debt becomes delinquent, I may be subject to additional processing fees. The debt may be referred to other collection agencies and collected by any means necessary and appropriate. This includes, but is not limited to: (1) A levy on disposable earnings to the extent provided in section 303 of the Consumer Credit Protection Act, 15 USC 1673, (if wages are levied, the levy will continue until the debt is paid in full); (2) Seizure of property without further notice; (3) Submission to the Federal Treasury for collection action, (4) Legal action resulting in a judgment against me for the full amount of this debt. Such judgment will adversely affect my credit rating.

NOTE: DHS intends to collect this overpayment from any adults who were members of the household at the time of the overissuance. Other adult household members and spouses must sign a separate agreement form. In cases of extreme hardship, DHS may reduce the amount of this debt.

REPAYMENT AGREEMENT: I understand and acknowledge that DHS has determined that I received an overpayment of benefits. I agree to pay back the amount shown above. If my household assets and/or income increase, or my ability to pay otherwise improves, DHS reserves the right to change the monthly repayment amount or require payment in full of the entire debt. I understand that refusal to sign this agreement will have no effect on my eligibility for assistance. I am signing this agreement of my own free will and no threat, duress or coercion has been used to make me sign it.

Client Signature X <i>[Signature]</i>	Social Security Number [REDACTED]	Date 11/12/09
Address 18421 Biltmore	City Detroit	State Zip MI 48235
		Phone Number [REDACTED]

DISQUALIFICATION CONSENT AGREEMENT

State of Michigan
Department of Human Services
OFFICE OF INSPECTOR GENERAL

Case Number		
919A		
County	District	OIG Agent
82	35	32
OIG INV#		Date
1000269800		6/29/2009

MS. TONYA COX
2293 GLYNN CT.
DETROIT, MI 48206

A person who intentionally violates Family Independence Program (FIP), State Disability Assistance (SDA), or Food Assistance Program (FAP) regulations can be disqualified from the program. We have evidence that you intentionally violated program regulations, and believe that you should be disqualified as follows:

<u>FS</u>	Program for	<input checked="" type="checkbox"/> 1 year (first penalty)	<input type="checkbox"/> 2 years (second penalty)	<input type="checkbox"/> Permanently (third penalty)
	Program for	<input type="checkbox"/> 1 year (first penalty)	<input type="checkbox"/> 2 years (second penalty)	<input type="checkbox"/> Permanently (third penalty)
	Program for	<input type="checkbox"/> 1 year (first penalty)	<input type="checkbox"/> 2 years (second penalty)	<input type="checkbox"/> Permanently (third penalty)
<u>FAP</u>	Program for	<input type="checkbox"/> 10 years for receipt of duplicate benefits for FAP.		

If you sign this Disqualification Consent Agreement, you will be disqualified from participating in the programs shown even if you do not admit to the facts in your case. The disqualification period is 1 year for the first offense, 2 years for the second offense, and permanently for the third offense or 10 years for receipt of duplicate benefits for FAP. You and the adults who were members of your household when you received the overpayment will have to repay the extra benefits you received. You will be expected to begin repayment while you are disqualified. Your benefits may be reduced during the disqualification period even if you do not agree to the facts.

If you agree to this disqualification, sign your name, and enter today's date in the box below. If you are not the head of your household, that person must sign a separate agreement. Return these signed agreements in the envelope provided. Keep copies for yourself.

Return a copy of all signed documents by _____.

You may contact the person below for additional information about this agreement.

Prosecuting Attorney or Representative (OIG Agent)	Phone Number
J. Lofton	313 852-2057
Address	
3038 W. Grand Blvd Ste 6-500, Detroit, MI 48202-6002	

A repayment agreement is enclosed and must also be signed and returned for this agreement to be accepted.

In agreeing to this disqualification a penalty will be imposed, which may result in a reduction in your household's benefits. Signing this agreement does not prevent the State or Federal Government from prosecuting you in a criminal court action or from collecting any overpayments.

Client/Former Client Signature	Date
X 	11-12-09

If you do not understand this, call your local Department of Human Services. Si Ud. no entiende esto, llame a su oficina local del Department of Human Services. مساعدة في فهم هذا الطلب - الرجاء الإتصال بمكتبك المحلي لإدارة الخدمات الإنسانية	AUTHORITY: 7 USC 2022; 7 CFR 273.16; MCL 400.60; R 400.3011; R 400.3129-R 400.3131; R 400.3159; R 400.3177-R 400.3179; R 400.5014 COMPLETION: Voluntary PENALTY: None
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"In accordance with Federal law and U.S. Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability. To file a complaint of discrimination, write USDA Office of Civil Rights, 300 7th St. SW, Suite 400, Washington D.C. 20024-2501 or call (866) 632-9992 (toll free) or (202) 401-0216 (TDD). USDA is an equal opportunity provider and employer."

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

Exhibit 4

REGISTER OF ACTIONS**CASE NO. 09-029622-01-FH****PARTY INFORMATION****Defendant Cox, Tonya****Attorneys**
Jeffrey W. Perlman
Court Appointed
(248) 351-2200(W)Muriel Deborah Trent
Court Appointed
(313) 585-4870(W)**Plaintiff State of Michigan****Paul D. Goodrich**
(248) 720-8543(W)**CHARGE INFORMATION****Charges: Cox, Tonya**

1. Fraud - Welfare (failure to Inform)\$500 00 or More

Statute
400602-B**Level**
.**Date**
12/01/2005**EVENTS & ORDERS OF THE COURT****DISPOSITIONS**

11/12/2009 **Disposition** (Judicial Officer: Braxton, Margie R.)
1. Fraud - Welfare (failure to Inform)\$500 00 or More
Pled Guilty

02/11/2010 **Sentence** (Judicial Officer: Braxton, Margie R.)
1. Fraud - Welfare (failure to Inform)\$500 00 or More
Fee Totals:
- Crime Victims Fee - \$60.00
(FEL)
- State Minimum Cost \$68.00
(FEL)
Attorney Fees \$250.00
Court Costs \$495.00
Fee Totals \$ \$873.00
Probation - (3 Yr, Comment: \$360.supv.fee;restitution to be determined)
Community Service - (150 Hours)

04/11/2011 **Amended Disposition** (Judicial Officer: Groner, David A.) Reason: Violation of Probation
1. Fraud - Welfare (failure to Inform)\$500 00 or More
Pled Guilty to Probation Violation

04/11/2011 **Amended Sentence** (Judicial Officer: Groner, David A.) Reason: Violation of Probation
1. Fraud - Welfare (failure to Inform)\$500 00 or More
Probation - (Comment: probation continued to 2/11/2012)

OTHER EVENTS AND HEARINGS

11/12/2009 **Recommendation for Warrant**

11/12/2009 **Welfare (AW/EX/AI/DC) Hearing** (9:00 AM) (Judicial Officer Braxton, Margie R.)
Parties Present
Result: Plea Entered and Accepted

11/12/2009 **Bound Over**

11/12/2009 **Parties Present** (Judicial Officer: Braxton, Margie R.)

11/12/2009 **Plea of Guilty Accepted** (Judicial Officer: Braxton, Margie R.)

12/09/2009 **Sentencing** (9:00 AM) (Judicial Officer Braxton, Margie R.)
Result: Adjourned at the Request of the Court

12/14/2009 **Sentencing** (9:00 AM) (Judicial Officer Braxton, Margie R.)
Result: Adjourned at the Request of the Court

02/02/2010 **Sentencing** (9:00 AM) (Judicial Officer Robbins, Kevin F.)
Result: Adjourned at the Request of the Court

02/11/2010 **Sentencing** (9:00 AM) (Judicial Officer Braxton, Margie R.)
Parties Present
Result: Sentenced

02/11/2010 **Order To Pay Court Costs, Signed and Filed** (Judicial Officer: Braxton, Margie R.)

02/11/2010 **Sentenced to Probation - Order Signed and Filed** (Judicial Officer: Braxton, Margie R.)

03/10/2010 **Amended Order Of Probation Signed and Filed** (Judicial Officer: Braxton, Margie R.)

03/10/2010 **Amended Order Of Probation Signed and Filed** (Judicial Officer: Braxton, Margie R.)

04/11/2011 **Arraignment On Violation Of Probation** (9:00 AM) (Judicial Officer Groner, David A.)
Parties Present

Result: Plea Entered and Accepted
04/11/2011 **Probation Violation Sentence (9:00 AM)** (Judicial Officer Groner, David A.)
Parties Present
Result: Sentenced
04/11/2011 **Warrant for Viol. of Prob. Set Aside/Warr Recalled-Clerk S/F** (Judicial Officer: Groner, David A.)
04/11/2011 **Attorney Appointed Order, S/F** (Judicial Officer: Groner, David A.)
04/11/2011 **Attorney Appointed Order, S/F** (Judicial Officer: Groner, David A.)
04/11/2011 **Certificate Of Official Court Reporter** (Judicial Officer: Groner, David A.)
04/11/2011 **Probation Continued/Extended Signed and Filed** (Judicial Officer: Groner, David A.)
01/31/2012 **Probation Closure Signed and Filed** (Judicial Officer: Braxton, Margie R.)

FINANCIAL INFORMATION

To pay on Adult Criminal cases [CLICK HERE](#)

	Defendant Cox, Tonya		
	Total Financial Assessment		1,022.00
	Total Payments and Credits		328.00
	Balance Due as of 06/17/2025		694.00
02/16/2010	Transaction Assessment		873.00
04/06/2010	Counter Payment	Receipt # 2010-09481	(128.00)
04/14/2010	Transaction Assessment		149.00
07/21/2010	Counter Payment	Receipt # 2010-18647	(150.00)
07/15/2011	Mail Payment	Receipt # 2011-15379	(50.00)

Exhibit 5

Original - Court

1st copy - Probation
2nd copy - Defendant3rd copy - Financial Services
4th copy Prosecutor

STATE OF MICHIGAN THIRD JUDICIAL CIRCUIT WAYNE COUNTY	ORDER OF PROBATION (FELONY) - NON PPO	CASE NO. 09-029622-01-FH
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ORI MI- 821095J Court address 1441 St. Antoine - Detroit, MI 48226 Courtroom Court telephone no. 313-224-2477

THE PEOPLE OF THE STATE OF MICHIGAN		vs		Defendant's name, address, and telephone no. Tonya Cox 40 Cedarbrook Circle	
Probation Officer:		CTN/TCN		SID	
Term: <u>3 years</u>				DOB	
OFFENSE:		1		3	
2				4	
<input type="checkbox"/> Judgment of guilt is deferred under: <input type="checkbox"/> MCL 333.7411; MSA 14.15(7411), Controlled Substance Act <input type="checkbox"/> MCL 750.350a; MSA 25582(1), Parental Kidnapping Act <input type="checkbox"/> MCL 762.11; MSA 28.853, Youthful Trainee Status <input type="checkbox"/> MCL 769.4a; MSA 28.1076(1) Spousal Abuse Act					

IT IS ORDERED that the defendant be placed on probation under the supervision of the above named probation officer for the term indicated, and that the defendant shall:

- Not violate any criminal law of any unit of government.
- Not leave the state without the consent of this court.
- Make a truthful report to the probation officer monthly, or as often as the probation officer may require, either in person or in writing as required by the probation officer.
- Notify the probation officer immediately of any change of Address or employment status. Defendant shall not change Residence without prior permission of assigned probation agent.

5A. Pay the following to the court:

Crime Victim Assessment fee (MCL 780.905) Felony/Misdemeanor	\$ 60
Fine	\$
Cost per year	\$ 495
Restitution	\$
Attorney fees	\$ 250
State Minimum Costs -	
Felony \$68.00/Serious, Specified Misd \$53.00/Simple Misd \$48.00	\$ 68
(per convicted count, not per case) MCL 769.1j	
Total	\$

5B. ☐ Total amount due as shown in 5A. shall be paid in installments of \$ 100 per month starting on 1/1/10 and shall be paid in full by the due date on the judgment of sentence unless otherwise ordered. Fines, costs, and fees not paid within 56 day of the date owed are subject to a 20% late penalty on the amount owed. If a cash bond/bail was personally posted by the defendant, payment toward the total is to first be collected out of that bond/bail and allocated as specified under MCL 775.22.

5C. ☒ Perform 150 Hours of Community Service per week ☐ N LIEU OF: ☐ Costs ☐ Attorney fees
 6. Pay a supervision fee to the Department of Corrections in the amount of \$ 120/yr. The fee is payable immediately and applies to all delayed sentences. A supervision fee may not be ordered or collected for defendants whose judgment of guilt has been deferred under MCL 750.350a. ☐ Total amount due may be paid in installments of \$ 100 per month starting on 1/1/10 payable to the State of Michigan.

- ☐ Serve Of the probation period in ☐ WCJ ☐ HWH ☐ SAI (Boot Camp) ☐ Tether 1 Days credit
- ☐ Enrollment/continue educational/vocational training. ☐ obtain GED
- ☐ Seek and maintain employment ☐ full time ☐ part time
- ☐ Undergo periodic urinalysis upon request of the probation officer. ☐ Non prescribed drugs of alcohol
- ☐ Participate in psychological evaluation and, if indicated treatment as directed by probation officer.
- ☐ Undergo substance abuse counseling and treatment until medically released. ☐ In-Patient ☐ Out-Patient
- ☐ Alcoholics Anonymous/Narcotics Anonymous treatment. 90 meetings for 90 days; then 5 meetings each week for one year, then 4 meetings each week thereafter and show proof of attendance to probation agent on demand.
- ☐ Participate in counseling required by MCL 333.5129(3) HIV
- Probation Violation ☐ all previous conditions remain in effect ☐ added costs for violation \$
- ☐ Other Pay restitution to MI Dept of Human Services

Failure to comply with this order may result in a revocation of probation and incarceration.

Date 12/18/2009 2/11/10Judge Margie R. Braxton37284
Bar No.

I have read or heard the above order of probation and have received a copy. I understand and agree to comply with this order.

Date

Defendant Signature

If the judgment of guilt is deferred as stated above, the clerk of the court shall send a photo copy of this order to the Michigan State Police Central Records Division to create a criminal history record as required under MCL 69.16a, MCL 600.4803, MCL 769.1a; MCL 771.1 et seq., MCL 775.22, MCL 780.826, MCR 6.445, 18 USC 922(g)(8)(c)

Exhibit 6



Claim Search

[Reset](#) [Search](#)

Search Criteria

Case #:

[REDACTED]

EDG #:

Individual Id:

Provider ID:

Claim #:

Claim Status:

Recoupable:

☐

All Statuses:

☒

[Reset](#) [Search](#)

Claim #	Case #	Program Code	Claim Status	Error Type	Overpay Start Date	OverPay End Date	Claim Amount	Outstanding Balance	Over Collection
[REDACTED]	[REDACTED]	FAP	Closed	Client Error	08/01/2018	08/31/2018	\$ 3.00	\$ 0.00	\$ 0.00
		FAP	Closed	Client Error	03/01/2021	03/31/2021	\$ 30.00	\$ 0.00	\$ 0.00
		FAP	Closed	Agency Error	10/01/2009	02/28/2010	\$ 1084.00	\$ 0.00	\$ 0.00
		FAP	Standard Recoupment	IPV Error	12/01/2005	08/31/2007	\$ 7229.00	\$ 1996.50	\$ 0.00



Claim Detail

Claim Information

Case #:	[REDACTED]	Case Name:	Cox, Tonya
Claim #:	[REDACTED]		
Claim Type:	Conversion	Error Type:	Intentional Program Violation
EDG #:	[REDACTED]	Establishment Date:	06/29/2000
Program Code:	FAP	Type of Assistance:	Food Assistance Program
Begin Date:	12/01/2005	End Date:	08/31/2007
Status:	Standard Recoupment	Status Date:	12/02/2024
Discovery Date:	06/29/2000	Delinquency Date:	09/01/2010
Source:	Court Order	WDU Review Date:	
Error Reason:	Client did not report	Repay Agreement Received:	
Status Change Reason:		IPV Type:	
Recoupment Percentage:		Recoupment Amount:	\$ 0.00
Court Order #:		TOP Referral Status:	Referral Withdrawn
		MARCS Referral Status:	
Last Notice:		Last Notice Sent Date:	
TOP Referral Notice Issue Date:		TPO - 1st Notice Date:	12/02/2024
MARCS Referral Notice Issue Date:		TPO - 3rd Notice Date:	
Debt Status :		Lottery Offset Referral Status:	Referral expired
Override Reason:	Administrative Decision	Over Pay Amount:	\$ 7229.00
Outstanding Balance Amount:	\$ 1996.50	Over Collection :	\$ 0.00
Adjustment Comments:	[REDACTED]		
Specialist Comments:			